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	08A020	A. BUILDING _____ B. WING _____	C 08/08/2018

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NEWARK MANOR NURSING HOME	254 WEST MAIN STREET NEWARK, DE 19711

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from August 2, 2018 through August 8, 2018. The facility census the first day of the survey was 64 (sixty four). An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies based on observation and interviews.	E 000		
F 000	INITIAL COMMENTS An unannounced annual survey and complaint survey was conducted at this facility from 8/2/18 through 8/8/18. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 64. The Stage 2 survey sample size was 29. Abbreviations/definitions used in this report are as follows: MD - Medical Doctor; Psychiatrist - physician for treatment of mental disorders; NHA - Nursing Home Administrator; DON - Director of Nursing; ADON-Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; cm-centimeter, measure of length; ADL - activities of daily living. such as bathing and dressing; Abnormal Involuntary Movement Scale (AIMS) - test to measure body movements the resident can not control, side effect of antipsycotic	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/30/2018

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F 000	Continued From page 1	F 000		

medications;
Antianxiety - drug used to treat feelings of worry, nervousness, or restlessness;
Antidepressant - drug to treat feelings of sadness;
Antipsychotic - drug to treat psychosis and other mental/emotional conditions ;
cognitive/cognition - mental action of acquiring knowledge and understanding through thought, experience and the senses;
Cross Contamination - the spread of germs and bacteria;
f/u-follow up;
GDR-gradual dose reduction;
Hematoma-collection of blood as a result of trauma;
Incontinent/incont/incontinence - loss of bowel and/or bladder control;
MAR-Medication Administration Record;
mg - milligram - measurement of weight;
MDS - Minimum Data Set/standardized assessment tool used in long term care facilities;
Non-Pharmacological - with out use of medication;
PO- By Mouth;
POS-physician order sheet;
PRN - as needed;
Psychotropic Medications - medication capable of affecting the mind, emotions and behavior;
Pt - patient;
pre-before;
post-after;
Prognosis - a prediction of the probable course and outcome of a disease;
q- every;
Sacrum-large triangular bone at the base of the spine;
TID- three times a day;
TB Testing - tuberculosis testing;

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F 000	Continued From page 2 Tuberculosis-lung disease; depakote-medication used to prevent seizures, treat bipolar mania or prevent migraines	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		9/6/18

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F 550	Continued From page 3 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by : Based on observation and interview the facility failed to ensure care was provided in a way that enhanced or maintained dignity for one (R14) out of 29 sampled residents who was observed multiple times with food debris on his face, clothing and equipment. Findings include: 5/7/18 - A quarterly MDS assessment documented R14 was severely cognitively impaired and required extensive assistance with hygiene. R14's care plan for self care deficit related to ADL's last updated 5/3/18 included interventions to please use U-Shaped pillow for cervical support to reduce neck leaning to far toward left shoulder. Make sure shoes are comfortable and not slippery. Resident prefers to wear slip on shoes. The resident requires maximum assistance by (1) staff with personal hygiene and oral care. 8/2/18 10:58 AM - During a random observation R14 was seen with a moist white film on his lips, dried orange food debris around his mouth, dried white food debris and a white crusted smear on the left side of his neck pillow, saliva down the length of his shirt and. dried yellow food debris on his shoes.	F 550	1. Staff cleaned and washed face, hands, wheel chair and changed bed linens R14. 2. Observation of other residents were made to ensure all were well groomed and kempt 3. Added task to PCC to change residents bed linen and replace pillow case to U-shaped pillow daily, change clothing protector after each meal and PRN, face to be cleaned and washed after each meal and PRN, change shirt, pants, shoes, ect. as needed for cleanliness. Residents wheelchair and seat cushion is assigned to be cleaned each night. 4. Audits will be performed 3 times a week and PRN by Staff Educator and/or designee until 100% for 4 consecutive weeks, then 1 time weekly until 100% for 4 consecutive weeks, then PRN to maintain compliance. Reported findings will be discussed through the QA process. ¿ See attachment 1	

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F 550	Continued From page 4 8/2/18 1:56 PM During a random observation R 14 was seen self propelling in front of the elevator with dried white food debris on neck pillow,and on back of chair, dried white food debris on seat cushion, dried white food debris on shoes, and saliva down the length of his shirt. 8/3/18 9:35 AM - During a random observation R 14 was seen seated in a wheelchair at the table in the day room wearing a soiled clothing protector (red stain and food debris the length of the clothing protector) E9 (CNA) was seated at the same table with R14, charting on a small electronic device in hand and was asked by the surveyor if R14 was in need of ADL care, and E9 stated "he was done [ADL care] already this morning." E9 then confirmed that R14's face was "messy", however did not remove the soiled clothing protector off of R14 nor was there any attempt to clean his face. 8/3/18 12:02 PM - During a random observation R14 was seen sitting at the end of the hallway, dried food debris at corners of his mouth, and continued wearing white terry cloth clothing protector with red stain and oatmeal food debris on from breakfast. 8/6/18 11:43 AM - During a random observation R14 was seen self propelling down the hallway in a wheelchair wearing a terry clothing protector with a red linear stain down the front, food debris on his shoes, and dried food on his neck pillow. August 2018 - Review of CNA documentation revealed hygiene was signed as completed daily for each shift. These findings were reviewed with E1(NHA), E2(	F 550		

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F 550	Continued From page 5 DON) and E3 (ADON) on 8/8/18 at 4:15 PM during exit conference.	F 550		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by : Based on observation, interview and resident council meeting it was determined that the facility failed to ensure the survey results were posted in an accessible manner for residents, family, and legal representatives to review without having to ask the facility for the results. Findings include:	F 577	" Survey Book relocated to appropriate area low enough for a resident in wheelchair to easily access. " Activities Director and/or designee will inform residents at every resident council meeting of the location of the survey book	9/6/18

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F 577	Continued From page 6 8/3/18 2:29 PM - Resident council meeting - 11 Residents attended the council meeting and when asked where the survey results were they answered they did not know where the results were but could ask for results. Upon leaving the facility each afternoon between 3:30 PM and 4:30 PM on 8/2, 8/3, 8/6, and 8/7/18 the survey results were not in a visible and accessible location. 8/7/18 11:25 AM - During the interview with E1 (NHA) requesting the location of the survey results and the surveyor was directed to the lobby. E1 did show the surveyor the actual location behind an easel and covered by a table runner. The surveyor explained that the results must be visible and accessible without having to ask the facility. 8/8/18 at 4:30 PM - These findings were reviewed with E1, E2 (DON), and E3 (ADON) during the exit conference.	F 577	. Location of the survey book is also posted on the activities calendar, which is distributed to all residents on a weekly basis and is posted throughout the facility. Audits will be performed by the Activities Director and/or designee on 4 random residents weekly until consistently 100% compliant for 3 consecutive evaluations. Then, bi-weekly until consistently 100% compliant for 3 consecutive evaluations. Then, monthly until consistently 100% compliant for 3 consecutive evaluation. Finally, one more evaluation will be performed the month following to ensure 100% compliance and residents are aware of the location of the survey book successfully. Audits will continue every 6 months to ensure compliance is maintained at 100%. " Audits will be performed by Activities Director and/or designee on 4 random residents weekly x4 consecutive weeks, then monthly x2 consecutive monthly, then quarterly until 100% compliance. To ensure residents are aware of the location of the survey book. " Survey book will be stored in a document holder affixed to the wall in lobby, labeled in large print for easy viewing access. " Education provided to nurses regarding attachment 2, location of form and the purpose of checking placement of the survey book. " First Floor Nurse will visually check daily for proper placement of survey book continuously to maintain placement compliance.Audits will be performed by Staff Educator and/or designee to ensure	

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F 577	Continued From page 7	F 577	survey book to being checked and documented correctly, weekly until consistently 100% compliant for 3 consecutive evaluations. Then, bi-weekly until consistently 100% compliant for 3 consecutive evaluations. Then, monthly until consistently 100% compliant for 3 consecutive evaluations. Finally, one more evaluation will be performed the month following to ensure 100% compliance and that we have successfully addressed the problem. Audits will continue every 6 months to ensure compliance is maintained at 100%. " Audits will be performed by Staff Educator and/or designee weekly x4 consecutive weeks, then monthly x2 consecutive months, then quarterly until 100% compliance. To ensure First Floor Nurse is visually checking daily the proper placement of the survey book. " Reported findings will be discussed through the QA process. ¿ See attachment 2 ¿ See attachment 2a ¿ See attachment 2b	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by : Based on record review and interview it was determined that the facility failed to conduct a comprehensive assessment for one (R 18) out of 29 sampled residents. Findings include:	F 641	1. MDS were received and modified for the following residents R18. All modified MDS were transmitted and accepted by CMS.	9/6/18

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F 641	Continued From page 8 Review of R18's medical record revealed: 8/20/15 - admitted to the facility. 3/31/17 - Care Plan initiated The resident is identified as high, risk for falls related to vision/ hearing problems and ambulatory dysfunction.; Actual fall 1/17/2018.; Actual fall 3/24/18 Sent to ER for evaluation; Actual fall 4/13/2018. 2/11/18 - Quarterly MDS section J1800, "Has the resident had any falls since admission or the prior assessment, which ever is more recent?," answered as no. R18 had one fall on 1/17/18. 5/10/18 - Quarterly MDS section J1800, "Has the resident had any falls since admission or the prior assessment, which ever is more recent?," answered as no. R18 had two falls since the last assessment, one on 3/24/18 and one on 4/13/18. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 8/8/18 at 4:15 PM during exit conference.	F 641	2. All MDS will be reviewed by DON or designee for accuracy in coding prior to submission. Findings of errors will be reported to Quality Assurance Committee. 3. MDS Coordinator will receive additional training on Coding and Assessment Accuracy. Plans to attend the Annual MDS workshop on Oct 2nd and 3rd at the Polytech Conference Center in Woodside, Delaware. 4. MDS Coordinator will perform random monthly audits based off of the previous months Assessment Reference Date, once 100% for 1 consecutive month, then audits will be performed quarterly to maintain compliance. Reported findings will be discussed through the QA process. ¿ See attachment 3	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:	F 676		9/6/18

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F 676	Continued From page 9 §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by : Based on observation, record review, and interview it was determined for one (R16) out of 29 sampled residents the facility failed to ensure that R16 could communicate clearly. Findings include: The following was reviewed in R16's clinical record: Admitted to the facility on 5/12/15.	F 676	" R16 care plan reviewed and modified to reflect appropriate communication methods. " All care plans have been reviewed and the alternative communication tools intervention on the communication care plan have been removed from all resident who are unable to use alternative methods to communicate. " All resident with be evaluated by Social Services/ADON and/or designee	

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F 676	Continued From page 10 7/16/15 Speech Evaluation - The last evaluation for R16 did not indicate any issues with communication. 5/30/17 - Care Plan - R16 had a communication problem related to a history of stroke. R16 has a goal to make basic needs known by responding yes or no to questions. Interventions include: adequate time to respond, repeat as needed, do not rush, request clarification to ensure understanding, face when speaking, decrease background noise, ask yes no questions, use simple consistent words and use of alternative communication tools as needed. 5/9/18 - Annual MDS Assessment indicates R16 is moderately impaired cognitively with unclear speech. R16 usually makes self understood and usually understands, but misses part of, or the intent of the message but comprehends most conversations. The ability to understand conversation has declined from clearly understanding to usually understanding from the previous MDS. 6/24/18 - Nursing Monthly Summary indicates R 16 is yes and no for clear speech and express needs to staff. 8/3/18 at 10:30 AM - During an interview with R16 it was difficult to understand responses to the interview questions. At this time E12 (LPN) was asked to clarify how to communicate with R16. It was revealed that R16 responds "yes" and "no" to questions. Communication was unclear and it was frustrating for R16 at the time of interview. 8/6/18 - 1:15 PM - Observation of communication between R16 and E6 (CNA) it was unclear what	F 676	upon admission and quarterly during care plan meetings to determine if alternative communication methods are needed and/ or effective. " Alternative communication dry/erase boards, EZ picture boards, bilingual picture flash cards are on each floor and available for alternative communication needs. " Education has been provided by Staff Educator on where to locate and how to use alternative communication tools and how to identify a change in communication status and who to report changes to. Education regarding alternative communication methods has been added to annual and PRN skills testing.Audits will be performed by Quality Assurance and/or designee weekly until consistently 100% compliant for 4 consecutive weeks. Then, monthly until consistently 100% compliant for 3 consecutive months. Then, bi-monthly until 100% compliant for 3 consecutive evaluations. Finally, one more evaluation will be performed the next quarter to ensure 100% compliance has been maintained and communication tools are successfully available for all residents use . Audits will continue every 6 months to ensure compliance is maintained at 100 %. " Quality Assurance and/or designee will perform audits weekly x4 consecutive weeks, monthlyx2 consecutive months, then quarterly until 100% compliance to ensure communication tools are available for use. " Reported findings will be discussed	

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F 676	Continued From page 11 R16 was saying to E6. E6 was asked what R16 said to E6 but did not know. 8/6/18 - 1:19 PM - Interview with E6 about communicating with R16 revealed that R16 responds to question with "yes" or "no". E6 asked if R16 wanted more to eat and R16's answer was not understandable. E6 asked again what R16 said and it was still unclear. E6 revealed that R16 just came here from another unit. E6 was not aware of any alternative ways to communicate with R16. 8/6/18 1:54 PM - Interview with E3 (ADON) it was confirmed that there was not an alternative method for communicating as mentioned in the care plan. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 8/8/18 at 4:15 PM during exit conference.	F 676	through the QA process. ¿ See attachment 4 ¿ See attachment 4a	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by : Based on record review and interview it was determined that the facility failed to ensure one (R 18) out of 29 sampled residents received adequate supervision to prevent accidents.	F 689	1. Care plan and Residents Status Sheet were changed after fall for R18 to reflected Do not leave unsupervised while in the bathroom also noting that resident	9/6/18

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F 689	Continued From page 12 Findings include: Review of R18's clinical record revealed: 6/13/17 - Care Plan, "TOILET USE: The resident is able to: toilet self with supervision." 1/12/18 - Fall Risk Assessment is 10, high risk for potential falls 2/11/18 - Quarterly MDS, Toilet use = 1,2 [supervision (oversight, encouragement or cueing) with one person assisting] and Transfer = 2, 2 [limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance) with one person assisting. 3/24/18 8:10 AM - The clinical record documented "resident was in restroom. Heard a loud noise. When entering the room resident was on the floor of the restroom. She stated she hit the rear of her head on the bathroom door. 2 x 2 cm hematoma noted to center, back of head. Resident denied pain. Small redness noted on sacrum. No other injuries noted. Pick up by ambulance at 9:15 AM to be taken to hospital." 3/26/18 - Incident/Accident Report, "Resident was in bathroom. CNA and myself (RN) heard a noise sounding like a fall. Resident sitting on floor in front of toilet. Stated she hit back of head on restroom door." 3/26/18 - Investigation Follow-up, "...R 18 requested to use bathroom - CNA walked her into the bathroom, then went to her side of room and began preparing her breakfast tray - CNA heard noise and R18 was on bathroom floor."	F 689	attempts to toilet self without assist at times. 2. All care plans were reviewed, all resident identified as a high fall risk had a plan of care adjustment to reflect Do not leave unsupervised while in the bathroom. 3. All resident with be evaluated by Social Services/ADON and/or designee upon admission and quarterly during care plan meetings to determine if Do not leave unsupervised needs to be added to the residents care plan due to a high fall risk. Education was provided by Staff Educator to all nursing department staff on new policy: Procedure for Supervision During Care and Do Not Leave Unsupervised During Care See attachment 5. ADON, MDS and/or designee will continue to evaluate resident for status change with all falls, quarterly and PRN. Care plans and Resident Status Sheets will be adjusted accordingly. 4. A trending fall log has been developed by the ADON to track falls that occur among the residents. The treading log will be used on a monthly basis to determine if resident's have an increase noted falls and a change in their status. Reported findings will be discussed through the QA process. ¿ See attachment 6	

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	08A020	A. BUILDING _____ B. WING _____	C 08/08/2018

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F 689	Continued From page 13 4/13/18 - E3 (ADON) states that her understanding of being supervised in the bathroom meant assisting in to the bathroom, ensuring resident is seated and call bell is within reach, reminding resident to ring bell once complete and then assist as needed. E3 verified that E3 did not think the CNA should have stayed in the bathroom. 4/26/18 - Care Plan, "TOILET USE: The resident is able to: toilet self with supervision .do not leave in bathroom unsupervised (patient at times will toilet self without alerting staff)" 8/8/18 -Surveyor was handed a document entitled "Procedure for Supervision During Care". E3 explains that this was created after R18's 3/24/18 fall. Parts of the document are listed below: Supervised care is defined as staff member should be available to assist resident with care at resident's request. The staff should monitor resident while promoting independence. Staff should be in the same proximity of the resident. Resident should be provided privacy and dignity during supervision while maintaining a safe environment. Do not leave unsupervised care is defined as the staff member must not leave the resident while completing the task. Staff should ensure resident safety before leaving their side by ensuring the call bell is within reach. These findings were reviewed with E1 (NHA), E2 (DON) and E3 on 8/8/18 at 4:15 PM during exit conference.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		9/6/18

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F 758	Continued From page 14 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in § 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		

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F 758	Continued From page 15 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by : Based on record review and interview it was determined that the facility failed to ensure medication regimens were free from unnecessary psychotropic medications when the facility failed to monitor AIMS testing according to facility policy for one (R44) out of 29 sampled residents. Findings include: The facility policy on Psychotropic Medication use last updated 7/14/17 indicated AIMS test will be performed every 6 months while resident remains on psychotropic drug therapy. Review of R44's physicians orders and clinical record revealed orders for multiple psychotropic medications including antipsychotics, antianxielyitics, and antidepressants, for treatment of behaviors. 3/18/17 - An AIMS test was completed on R44. 6/4/18 - An AIMS test was completed on R44. A care plan for R44's use of psychotropic medications related to behavior management initiated on 3/18/17 and last updated 10/27/2017. Included the goal for R44 to be/remain free of psychotropic drug related complications, including	F 758	1. AIMS were reviewed and updated for the following resident R44. 2. All residents receiving Anti Psychotic medication were reviewed to ensure an AIMS assessment was placed on their charts, each resident was evaluated for abnormal movements (tardive dyskinesia) and documented appropriately. 3. AIMS will be completed every six months for all residents receiving Anti Psychotics medications. Any abnormal results will be reported to MD for further evaluation. 4. Random audits will be completed by ADON and/or designee monthly until 100 % compliance for 3 consecutive months and then reviewed quarterly during each care plan review. Reported findings will be discussed through the QA process. ¿ See attachment 7	

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F 758	Continued From page 16 movement disorder, discomfort,hypotension, gait disturbance, constipation/impaction or cognitive/ behavioral impairment through review date. Interventions for this care plan included administer psychotropic medications as ordered by physician and monitor for side effects and effectiveness each shift. Monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, ... (shuffling gait, rigid muscles,shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression,suicidal ideation's, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. During an interview on 8/8/18 at 11:04 AM with E 3 (ADON) it was confirmed that the facility failed to complete AIMS testing required for R44 because of the use of psychotropic medications in the recommended time frame of every 6 months. The facility failed to complete AIMS testing on R 44 according to facility policy of every 6 months. These findings were reviewed with E1(NHA), E2(DON) and E3 (ADON) on 8/8/18 at 4:15 PM during exit conference.	F 758		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		9/6/18

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F 880	Continued From page 17 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 18 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by : Based on observations and interviews it was determined that the facility failed to maintain an infection and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Observations made during a random dining observation and during a random medication observation revealed facility staff failed to complete adequate hand hygiene on 3 separate dates and (8) occasions. Findings include: The Centers for Disease Control and Prevention (CDC) article titled "Clean Hands Count for Healthcare Providers states, "...Hand hygiene means cleaning your hands by using either	F 880	1. Education and In service provided by Staff Educator to all staff with hand washing policy, proper technique and time required to wash hands per facility protocol. 2. Observations performed by Staff Educator, observed hand washing during meal times and medication passes to ensure proper hand washing technique performed. 3. Staff Educator observed all staff members (all departments) performing proper hand washing technique per facility policy and protocol.	

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F 880	Continued From page 19 handwashing (washing hands with soap and water)...antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel)...Clean your hands:...Before and after having direct contact with a patient's intact skin...After contact with blood, body fluids or excretions...After contact with inanimate objects (including medical equipment)...After glove removal...Techniques for Washing Hands with Soap and Water:..When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended...rub your hands together vigorously for at least 15 seconds, covering all surfaces...Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable...". (https://www.cdc.gov/hand hygiene /providers/index.html) The facility policy on Hand Hygiene last updated February 2018 indicated hand washing techniques should include application of soap and lather for at least 45 seconds. 8/2/18 - During a random dining observation on the second floor from 12:03 PM through 12:46 PM the following staff members were observed failing to complete adequate hand hygiene related to required minimal 15 second length of time for hand washing: E11 (FSD, Food Service Director) - 12 seconds E13 (CNA) - 5 seconds 12:24 PM E13 - 11 seconds 12:46 PM E13 - 8 seconds 8/3/18 - During a random dining observation on the second floor at 11:58 AM the following staff members were observed failing to complete adequate hand hygiene related to required	F 880	4. Audits will be performed by Staff Educator and/or designee weekly until 100% compliance for 4 consecutive weeks, continue with quarterly and PRN observations per regulation ensuring hand washing technique is being performed properly. Reported findings will be discussed through the QA process. ¿ See attachment 8	

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F 880	Continued From page 20 minimal 15 second length of time for hand washing: E15(CNA) - 3 seconds Immediately after, E13 - 10 seconds 8/7/18 - During a random dining observation on the second floor the following staff members were observed failing to complete adequate hand hygiene related to required minimal 15 second length of time for hand washing: 11:04 AM E16 (CNA) - 10 seconds 12:36 PM E14 (CNA) - 11 seconds During an interview on 8/6/18 at 10:00 AM with E 8 (RN) it was reported that expected time frame for adequate handwashing was at least 30 to 45 seconds according to facility policy. These findings were reviewed with E1(NHA), E2(DON) and E3 (ADON) on 8/8/18 at 4:15 PM during exit conference.	F 880		

AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care
Residents Protection

Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Newark Manor Nursing Home

DATE SURVEY COMPLETED: August 8, 2018

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from August 2, 2018 through August 8, 2018. The facility census the first day of the survey was 64 (sixty four). An emergency preparedness survey was also conducted during the same time period. There were no emergency preparedness deficiencies based on observation and interviews.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed August 8, 2018: F550, F577, F641, F676, F689, F758 and F880.	 Cross Refer to the CMS 2567-L Survey completed August 8, 2018: F550, F577, F641, F676, F689, F758 and F880	9/6/2018

Provider's Signature _____ Title Administrator Date 10-30-18